MEETING

HEALTH AND HUMAN SERVICES AGENCY

RURAL HEALTH POLICY COUNCIL

TENAYA LODGE

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YOSEMITE, CALIFORNIA

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REPORTED BY:

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Mauricio Leiva, Managed Risk Medical Insurance Board

Ruben Lozano, Department of Mental Health

STAFF

Pablo Rosales

Kerri Muraki

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PROCEEDINGS

CHAIRPERSON CARLISLE: I know everybody is anxious to get going with the meeting of the Rural Health Policy Council.

Good morning everyone and welcome to the Tenaya Lodge. I am David Carlisle, Director of the Office of Statewide Health Planning and Development and Chair of this morning's Rural Health Policy Council public meeting.

Dr. Stephen Mayberg, Director of the Department of Managed Health, who normally chairs these meetings, had an unavoidable scheduling conflict and couldn't be with us. So I'll be chairing the meeting, and again, thank you everyone for being here.

Before we go further, of course, as everyone knows, last night marked the initiation of military action in Iraq and I'd just like to ask for a brief moment of silence in support of the U.S. troops in the mideast. Thank you.

(Brief moment of silence.)

CHAIRPERSON CARLISLE: Thank you very much everyone.

At this point, I'd like to give special thanks to Sharon Avery and the Rural Health Care Association's Rural Center Board for the invitation to have the RHPC meeting in conjunction with its 18th Annual Rural Health Care

Symposium.

Everyone today has an agenda and you will see that we have a special presentation by Mr. Pablo Rosales, Deputy Director of the Health Care Workforce and Community Development Division of OSHPD, on developments that his division is initiating in terms of the workforce area.

At this point I'd like to ask the members of the council to go ahead and introduce themselves for the audience, going from my left to the right.

COUNCILMEMBER MCNEIL: I'm Maureen McNeil, and I'm representing Richard Watson who is Director of the Emergency Medical Services Authority.

COUNCILMEMBER SAVIANO: Elizabeth Saviano, on behalf of the Director of the Department of Health Services.

COUNCILMEMBER LEE: Bud Lee, the Executive Director of the Rural Health Policy Council, also the Chief Deputy Director at the Office of Statewide Health Planning and Development.

COUNCILMEMBER LEIVA: Mauricio Leiva, I'm representing Lesley Cummings from the Managed Risk Medical Insurance Board.

COUNCILMEMBER LOZANO: I'm Ruben Lozano. I'm here on behalf of Dr. Mayberg who is the Director of the Department of Mental Health.

CHAIRPERSON CARLISLE: And now before Bud Lee

gives his activities update, I'd like to also point out that we have a public comment period. And in order to make comments, we'd like to ask you to fill out these cards that are available either from folks in the back of the room or the back table. If you have a card, you can raise your hand and Kerri Muraki or Raquel Lothridge at the back will take them for you, and we can go ahead and put them on the agenda for the public comment period.

Well, at this point, Bud will make his activities update.

COUNCILMEMBER LEE: Good morning everybody, it's always a pleasure to come to this symposium. Tenaya Lodge is a great place to get together.

I wish I had something more definitive to tell you about the State budget. I know that that is something that is weighing very heavily on everyone's mind, and in particular, issues related to the county realignment. Just to bring you up to date in terms of the process and where we are, there are budget hearings that are going on now. They are largely informational where people are testifying about the potential impacts of the proposed county realignment functions in both health services as well as social services. No decisions will be made on those until after about May 15th. For those of you who are familiar with the state budget process, it's affectionately known as the May

Revise where all the caseload and workload estimates are used to update the proposed budget that was issued in early January. And it's that time then that the Legislature will have more definitive numbers with which to work.

I think most of you have some liaisons in Sacramento who monitor budget activities for you. I would encourage you to stay very close to them so that your views can be heard through those organizations. We're really into a period of about six more weeks of intensive negotiation until we know what will happen, more likely in the latter part of May and during the month of June. There are other issues related to the budget, I think which I included in an earlier update issued a month or so ago.

By the way, if we ran out of copies of my most recent update, which was on the back table, if you would like one and you didn't get a hard copy, we're having copies made and they will be available later on during this meeting. And Kerri is saying they are available right now.

I want to bring you up to date in terms of some things, some initiatives, that the Council has launched at the behest of some of you, as well as some others who may not be able to be here today.

We've adopted a working group model. I think I've discussed this at various other meetings where you may have attended or at last year's meeting like this. A working

group model where a group gets together of interested parties from both the public and private sectors, and the group has a lifespan of however long the group has value or that the Council is contributing value to that process. For example, there is a working group that is moving ahead addressing specifically rural healthcare workforce issues. We're having a meeting on March 27th. We've had a couple of early meetings, they've been kind of formation oriented, figuring out what it is that we want to try to tackle.

A couple of things are coming down the pipe in kind of the near and then longer-term orientation. In the near-term orientation, we've picked up on the fact that there are some communities where for workforce development, healthcare workforce development, you can grow your own. And the intent here is with the knowledge that there are people who may come to your community to serve in the rural workforce because they are incentivized to do so by some grant or loan repayment mechanism, but they will often leave after that obligation is done.

And in order to have kind of long-term retention within a community, we need to figure out ways to educate people in that community, options such as distance learning through telehealth networks and those types of things are going to be on our agenda. A little longer term, because it involves perhaps some political diplomacy, has to do with

expanding the number of mid-level practitioners. Clearly there are areas where getting physicians or dentists into rural communities is a very big challenge. There are already existing mid-level programs that you're very familiar with, the physicians assistants, the nurse practitioners and others.

One area that seems to have surfaced as an area where some good could be done would be the oral health area. So we're going to be taking a look at whether we can do some facilitation in terms of policy development to expand the oral health mid-level practitioner capability, just to extend access into more remote and rural areas.

That would be what I would characterize as a rather large-scale working group that's going to have a lifespan, I believe, of perhaps quite a few years. Because once we solve one, we can move on to another. The opportunities for workforce development are almost limitless now, as you know.

Another working group that we're facilitating, I would say the mid size, is the Managed Care Geographic Accessibility Standards have been -- the Department of Managed Health Care has been directed to reexamine and evaluate the current Geographic Accessibility Standards currently pegged at -- and I think people are familiar enough so I can go right to the jargon, the 15- and the 30-

mile rule, standard, guideline, there seems to be a lot of ambiguity out there as to what that exactly is. We convened a group starting with the Rural Health Center Board here and the Department of Managed Health Care and it is being expanding to include other groups.

Again, in the most recent report that we issued, the update, I referenced a meeting that we just had with the Department of Managed Health Care Legislative Liaison, and without tying him down to any specific timeframe other than very soon, they are going to be launching a process that they're still working out the mechanics of what it's going to be. But what they're kind of thinking about is should they get together with individual stakeholder groups, say like the provider community, and then another group being the plans and another group being consumers, should they get together with them individually first to try to scope out what their concerns are about these Geographic Accessibility Standards and then convene everyone into a large group, this is all prior to putting some regulations on the table to talk about them, or should they just go for a big group and have a real set to. They're thinking about that. And Herb Shultz is the legislative liaison for the Department of Managed Health Care and in the update I've given you his e-mail address and you should feel free to share your thoughts with Herb.

The other part of the process that they're thinking through is should they come to these meetings without any paper in terms of what their thinking is about draft regulations. That keeps things wide open at the beginning. Or should they come to a meeting with some draft regulations so people have something to react to. They're working through that and thoughts that you may have to contribute to their thinking I know would be appreciated.

That's when these start evolving. I think we can assume it's, you know, less than a month. I don't want to bind him to a couple weeks, but it's soon, within the month, I would expect. And then that's going to stimulate a process that will eventually evolve into a formal regulation process going through the Office of Administrative Law and all that type of thing. It promises to be a very challenging effort, because there are some pretty widely held views on these issues.

The one thing that Herb Schultz asked me to pass on to you is that if you want to resolve issues related to contracts and payment schedules and those kinds of things, they're willing to listen, but it's not part of his regulation process. It would have to be in a different venue, because they're trying to stay focused specifically on the Geographic Accessibility Standards.

On a little smaller scale, but still very

important, for those of you who may know situations in your counties where you have a county alcohol and drug treatment program staffed by a variety of practitioners, both licensed and certified and unlicensed, if you've had challenges in working with health plans who are contracting with the Healthy Families Program, we have been facilitating a process to try and see if we can break down some barriers that county alcohol and drug programs have had in contracting with health plans that are serving the Healthy Families Program. Specifically, now we're talking about children under the age of 18 that are in need of alcohol and drug treatment.

The health plans have traditionally had some concern about using practitioners who aren't licensed. We discovered through a long process of discussion with the Department of Managed Health Care that that's not a barrier and health plans don't have to contract only with licensed practitioners. Other issues have surfaced that the plans are concerned about, accreditation issues.

So we're going to have one more meeting, getting all these people around the table, and we're going to see if we can get to some resolution short of having to go to a legislative process, because we all know how difficult and challenging that can be. So hopefully by the next time we get together or I issue my report, I'll be able to say,

well, we've found a way to work things out or we haven't and it's going to be a legislative battle.

But those are the examples of the type of working groups that we have, I think, discovered that the Council can serve you well in terms of we don't bring, you know, a specific agenda that we want to promote other than to make sure that people like yourselves have access to tables where discussions like this go on and what we can go is convene. We don't come to the table with a particular agenda of our own, it makes other people who need to come to that table too less suspicious of us because we don't have a particular ax to grind other than to represent you and get you to the table.

So if there are other issues like what I have just described, ranging from large to small or medium, that you think could be helped simply by us creating a venue in Sacramento or in your locale with people, agencies in the state government or private sector associations, special interest groups that you wouldn't normally or naturally meet with, let us know. I can't promise we're going to be able to solve everything, but at least we can hear you and help you understand how it is that we may go about helping you. Okay.

Other items of general news. There is the report to the Legislature which you've been hearing about for a

number of months now. It's under review, going through the process in the executive branch. I hope to have news about that soon, and we did make some recommendations in there that I hope that you will find helpful.

Also just a notice or reminder, back there on the table there's a short piece also about the Small Grant Program is getting ready to launch. That has not been affected materially by the state budget. That's again funded out of the Tobacco Tax Program. It's got a timeline. April 28th is the first key date in your mind, if you're thinking about wanting to submit a response to our request for proposal. April 28th is our release date. So if you're not on a list to receive our RFAs, please e-mail us and let us know that you would like to receive one.

Also, just to remind you also, we do have Job Lines Program. We have some materials in the back, again, on the status of the job lines, the hot line, and please feel free to use that. I know many of you do.

We also have a couple of maps back there. We have some new mapping capability. You now can see all of our maps. We've got the critical access hospital map, we've got the designated rural hospital map.

And that's really about it in terms of where the Council is. I'll be around for questions later on or if you have any of me during the public comment period, I'd be

happy to address them. Thank you very much.

CHAIRPERSON CARLISLE: And thank you, Bud.

Now we will move to the next item on the agenda which is a presentation by Deputy Director Pablo Rosales from the Healthcare Workforce and Community Development Division of OSHPD.

As Pablo is setting up, I'd again like to remind everyone that we certainly encourage public comment. If you do wish to make a public comment, fill out one of these cards which are available on the back table there and Jessica, Kerri or Raquel will pick it up from you and bring it up to me and we'll go ahead and get you in the queue.

DEPUTY DIRECTOR ROSALES: Good morning everybody. By a show of hands, can I please ask how many people are really familiar with the operations of OSHPD?

Okay. When I get in trouble, I'm going to call for you guys to give me some answers, okay, to help me out.

Yesterday morning, or actually yesterday afternoon, I was sitting in my office and like a typical bureaucrat trying to push some papers around and making sure that I had all my work done. And I have been given this real fancy computer with all the bells and whistles that you can think of, and this is from somebody who still uses a paper and pencil to do stuff, okay. But my supervisor, Bud, pops his head in the door and says are you thinking of

coming to the meeting we have scheduled, and I look up and realize that I have a meeting scheduled.

And, of course, the essence of the story is that right now everybody at OSHPD is really very, very busy. I mean, with the issues that we have with the budget, there's been a lot of impact in terms of our operations. But I'm sure I'm preaching to the choir, because there is a trickle down effect. I'm sure, that most of you have less money to work with, you have growing demands, you have less staff, and things are not easy at this point, okay. So I just wanted to share with you that everybody at OSHPD, not just our division, is really cranking it up and we're really working very, very hard.

This is the vision statement for our department, "Equitable healthcare accessibility for California." They are five little words, but they are five little words that really make it very difficult for us to meet all the intents of what we want to do for the state. I've said it publicly and I will say it again, when people ask me well, how do you like working for OSHPD, and I say, you know what, the only trouble I have working for Dr. Carlisle and for Bud is that every time we go somewhere it's that what can we do for this community, which means there's more work for the division. But by the same token, it's kind of hard not to enjoy that kind of enthusiasm and willingness to have a department be

able to be more proactive in community matters.

I come from the community side and I truly appreciate that when a state department does engage in terms of whatever activities a community finds as their priority, their needs, not what Sacramento and people up north think you should have. So I like that kind of engagement for our department, I really enjoy it.

By the same token, we are facing a growing aging workforce. We have, what, six to eight million people that aren't insured, and of special concern for me is the children. We have two million plus children that aren't insured. We are having competition. The healthcare area is no longer where people kind of come to, they want to go out and make more money is other areas that are less difficult to work in. We have the issue of having to identify and deal with cultural competency and enlisting these. So there are a number of barriers and obstacles we're having to face in order to meet the intent of our five little words here. So there's a small message, but it carries a big burden on us.

Obviously to meet your vision, you have to have a mission. And I don't want to read the slides to you, but just to let you know, if you'll note the bolded portion, "promoting a diverse and culturally competent healthcare quality," and also, "facilitating development of sustained

capacity for communities to address local health needs." This is a very big portion of what my division does, the Healthcare Workforce and Community Development Division. Our emphasis is very strong on these two particular items. And there's obviously more, but in order to craft a reasonable mission statement, this is what we're focusing on.

Not everybody raised their hands in terms of knowing who OSHPD was and what we do. So I want to give you just a thumbnail sketch, a very brief thumbnail sketch, of who we are and what we do.

You have the Healthcare Information Division, which in very simplistic terms pulls in information from the public, hospitals, communities, et cetera. Then you have the Healthcare Quality and Analysis Division, which churns these numbers, this information and statistics and spits out reports and does some very fine work by the way. Dr. Carlisle and I were in a meeting down south in LA I'd say about three months ago and we come to find out an organization is paying a consultant to find information that OSHPD has. And I think it's very disheartening because in this time where money is so tight, agencies can't afford to be hiring people when a state agency does this for you. So we're trying to be more proactive and get the word out that we are here to be a service orientated facility.

And, of course, we have the Facilities Division, who is into the seismic safety integrity area. And, of course, that's the big issue right now because hospitals are having to make hard choices. Do we retrofit or do we not see patients. So that's something, again, that's a real burning issue. And then we have Cal-Mortgage, and Dale's here today, as a matter of fact, whose division secures loans so that health facilities are able to secure loans so that they can either build upon or expand or develop these sites. And then you have your typical Administrative Division, your personnel, your accounting. And last, but not least hopefully, our division, the Healthcare Workforce and Community Development Division.

That is the basic structure of OSHPD. We are a small department. We are about a $52 million budget department, less than 400 people, especially with the freeze exemptions and the budget cuts, I think we've gone smaller, but the work is not stopping. I don't think we're saying we're not going to be able to do stuff. We have a very proactive management team and I think we continue to meet all our mandates in the best possible fashion that we can.

I also wanted to mention as an appendage to the Department, and I say that with respect, is obviously the Rural Health Policy Council. And then we also have the Health Professions Education Foundation which provides

scholarships and funding for nurses. It's run under Angela Smith.

In addition to that, we have statutory boards and commissions that we respond to and deal with and interact with. Of particular interest for my division is the California Health Manpower Policy Commission, and we respectfully refer to it as the Commission. The Commission is an advisory board to the Director. The Commission is a very, very -- it's a ten-person board and it's real interesting, because when I first came on board, I knew nothing about what they did and then I realized how important their role is. In this particular case, for example, they do the ranking of all the applications for the Song-Brown Family Physician Training Program. They also rank the family nurse practitioners and physician assistant applications. So they have a real tough job, especially after the funding starts to be reduced and it's harder to make cuts of good programs when you know they're actually good but you just can't afford to fund them. So they had some real difficult decisions to make and I have seen their decision making operation and I have to tell you, you talk about a fair and equitable board. I am very impressed by the quality of people that we have on this commission.

And then last, but not least, in terms of some of the major functions that we do, right now some of you may or

may not be aware that we're in the process of reconfiguring the state in terms of the HPSAs, the MSSAs, as we call them, and the Commission is the body that approves recommendations when we bring them forward to the committee. So again, some tough items that they had to deal with, but nonetheless, they've done so very professionally and I'm very impressed by them.

So you might ask what does the Division do or how do you fit into the scheme of things. Well, I've got a desk, it's very old and it's very big, and we have piles of stuff that we have on it. And just when I'm starting to feel sorry for myself, I go to Bud's office and I look to see that he's wearing two or three hats and I say I better be quiet and go back to my cube, because I'm not as busy as he is. But nonetheless we are very busy. Our purpose is to support healthcare accessibility through the promotion of a diverse and competent workforce.

And then the last part which I really want to emphasize is providing analysis of California's healthcare infrastructure. Well, obviously, that all ties into the vision statement and to our mission. One of the problems that I believe and I've expressed to Dr. Carlisle and to Bud is that I think that our division has been remiss in terms of the data collection process. I am very much a numbers person and obviously you know that to run a program and to

validate your programs, you have to have the numbers when you go forward for funding. People want to know what you did for their money, whether it's the public, legislators, or even other concerned citizens that really aren't involved. So we've been remiss in this area, so we're looking to see if the Division can be more astute in that particular area.

For the purposes of programming, we still use a straight line table of organization and development. We still use the straight line, you know, who reports to who and what. However, recently, because of the -- and I'll get into the details more later, because of the funding situation and the way it is, because we've lost six people in the division through retirement or through the loss of programs and funds, and I don't know about you, but six out of thirty for me is a significant cut in terms of when the work has not gone away, we have to redistribute the workload, it's still there.

What we're trying to do now is rather than have the staff look at the division in straight lines and charts of that nature, we're asking for the staff and we're all trying to keep this in mind, that there is a continuum of services. In other words, there is not one program that runs independently of each other. So we're trying to promote an organizational operation that has this kind of

semblance where there is a continuation. There is no beginning, there is no end, it's just a continuation of services.

I want to run through the actual programs real quickly. It's not that I want to avoid it, because all the programs are very significant to us, but I don't want to spend too much time on the programs themselves. So first we have the National Health Service Corp/State Loan Repayment Program. Obviously, as the slide reads, it's an authorization to repay educational loans to bring people into the HPSAs, the Heath Professional Shortage Areas. It's an enticement program. Obviously, we're trying to use it to recruit people, and it's worked well. In fact, this year it's worked too well because we received our allocation and two months into the breakout of the funding, we were able to distribute close to a million dollars in terms of loan repayments. The commitments were made very quickly.

We have set aside a few dollars for the mental health component, because we just added mental health to our program. It was something that was not in the mix previously.

We're also trying to do some things in this program that were not done before. This program historically had been a first-come first-served basis. And once you got your application in, you were funded, if you

qualify. Well, I had two concerns with that. The first concern being that if you fund in that fashion, you may leave people out and there's other disciplines that are involved. You know, there are a number of disciplines that are involved, so some disciplines are going to be left out. So we're trying to find an equitable funding distribution. We may call upon some of you in the public to say, okay, if you had the magic wand, how do we distribute this money equitably to make sure we have coverage for mental health workers, for physicians, for attendants, for nurses, et cetera, et cetera. So we're trying to find that distribution.

The other thing that concerned me is that the money seemed to be distributed geographically only in certain concentrations and I have a problem with that. Again, having been in the community, unless you're able to see the particular nuances and needs of the community, you may forget about that. So I'm asking staff to look to see how we can distribute the money geographically throughout the state, not just in one concentrated area. So those are the things we're doing there.

The other thing, there's two other things that are on there, is that we are now in discussions with the feds and we may be taking over their portion, their counterpart of the Federal/State Loan Repayment Program. I'm a little

bit concerned, because there's quite a bit of work that's going to be coming as a result of that. But by the same token, I think we do need to have the programs within the division. It would make it much easier for you to be able to say, hey, is there money? No, I don't have money in one pot, but, guess what, I may have it in another one. So we are looking forward to that and I think we will be able to work out the bugs and be able to get it in there.

Also, in addition to that, in fact I just had a conversation this morning real quickly where we work very closely with the Medical Board and the Dental Board and they're trying to distribute their 982 money. I had a conversation with Ron Joseph, the Executive Director, just a couple of days ago. And my understanding is that as of two days ago, there was only 17 applications for some of the money, and $3 million was available for physicians. So if you guys have questions about that, I'd be glad to answer them or turn you over to Ron and his group. But we work very closely together, and I said to Ron, I don't want to answer questions for your programs, but by the same token, if I'm out in the street and I have information to share, I will share it with them, and he was more than happy for us to do that. We work very closely together in that area.

Our Song-Brown Program. I'm very impressed by this program. I really like what the program does.

Obviously, it tries to entice and recruit people to go into underserved areas, physicians, NPs and PAs. But more than that, we were looking at some numbers the other day. We had a legislative call and trying to look at what the program does. And for year 01/02, we were looking at the fact that the Song-Brown, just the residency programs provided over 350,000 patient contacts. That to me is significant. That to me says that the program is working at this point and I'm very proud of what some of the programs are doing. They really put out a good product. Also the fact that the figure is skewed. We get anything between 36 to 45, so I'm going to use 45 to give us more credit, okay.

But 45 percent of the trainees under the Song-Brown program end up working in underserved areas. And I think, again, that's very significant since we're having to not -- the story is that there's plenty of doctors, but many of them don't want to work in underserved areas. This program is really focusing and trying to get them into those areas. And also 60 percent of the family physicians that are trained annually in the state of California come out of the Song-Brown Program. So it seems like in a nutshell when you look at the program and the dollars we put into it, we're getting a lot of bang for the buck in this program.

Every time we flip the chart I keep saying wow, but there's something more exciting down the road, because

there is. This is something I'm very proud of right now, the Cooperative Agreement. The staff has done a real wonderful job in terms of trying to go out or, like I said earlier, we're trying to reconfigure the whole state. By reconfiguration, meaning that we're trying to pull some of the less rural areas, less densely population rural areas away from the urban areas so we can get a more appropriate geographic distribution evidence in the state, which means -- translates into the benefit to the community. Because this will make you eligible for either, for example, state loan repayment program or higher reimbursement rates. And we're doing it with a very strong consensus in the community.

What actually happens, if you don't know, is we proactively go out to the community, we call the community and say we're going to be in your area and we want to see if we can reconfigure your service area, and we call a number of different players, whether they be clinics, hospitals, board of supervisors, CEOs, anybody that's impacted by healthcare workforce issues and funding, and bring them to the table. We've got a real exciting software right now called our GIS, Geographical Information System. Anyway, the bottom line is that we're able to do realtime configurations.

Just to let you know, my understanding is that the

last time LA was done, it took two years to do, this time it took us six weeks. And I was very impressed because I'm not a techie, but when I went down there and I saw what we were able to do in LA. In fact, for the first meeting that I went down there, I took a flak jacket because I was ready for the fists to fly, you know. Because everybody has issues in terms of wanting to have their particular service area covered and understandably so. I've been in that particular position. But when we saw what the GIS did, the realtime numbers, and people saw there was no hidden agenda, that we were being very straightforward in trying to help different communities, and actually we were able to work it out with a gentlemen's agreement and they were very impressed. And we got some real good press from this. We're in about 50 percent of the state. Fifty percent, especially after doing LA. I think we've had difficulty in one area, and the only reason we had difficulty in one area is because a couple of the representatives of the community didn't show up, and rather than move forward with a recommendation and not enough participation, I decided to cancel that and said, no, let's redo it again with more players at the table. So it wasn't so much of a big political thing, but rather it was not enough participation. And we've always felt that without community participation, you know, I'm not willing to make decisions for the

community in that sense. So we wanted them to be involved.

Under the Health Careers Training Program. This program is very close to my heart in the sense that I've been used to working with a lot of communities and working in collaboration with communities. And I think, especially as we move forward with continued budget deficits, this is one particular way to handle a lot of issues. It's real difficult sometimes to bring people to the table and say, okay, rather than big government coming down and saying this is what you need, we'll come down with the attitude that says, okay, what are your needs in the community and how can we help you.

Right now we have two collaboratives, one in Fresno that I'm more closely tied to. And one of the nice things there is that the Fresno collaboration, there are some people in this room I'm certain that know about this. You know, we've been able to come up with some reasonable goals and objectives, because when you first start you have a laundry list that's about a mile long, but knowing that there's limited resources of time and staff, so we try to narrow it down to a more realistic approach. And my job is to go back to Sacramento and try to find the resources that we have available at the state level to help the communities. So we've got a staff person assigned to that particular collaborative. We've got one assigned to one in

Sacramento. And in addition to that, even though they're not formally put on paper, we have several other collaboratives that we're providing to.

This one here is something that Bud alluded to. When we're trying to find different ways to deal with a budget deficit, one of the biggest areas that comes up is the scope of practice. If you've got somebody in the community that can do X number of steps in a particular area of service, why isn't it that we can't try to extend their scope of practice and see if they handle it with the proper supervision. So this is a real exciting program for me too, but unfortunately I don't think it's been utilized appropriately, only because if you have the funding, you're not going to worry about it. But now that we're in the midst of a budget crunch, I think this program will probably take off. And we're doing a couple of things right now. We're trying to come up with a plan in terms of finding out what can we do in the oral health care area.

So I'm real excited about that and I think the CPCA is real excited about that because we have never utilized it, and unfortunately, I don't think we've advertised it enough, and I think that's our biggest problem. It's not that the community doesn't want to do it, but I don't think the community is aware. So that's our flaw. We're looking to correct that and I'm offering it up

to you right now. If you have questions on this, please feel free to ask me.

What I did initially when you come in, I brought in some late summaries. Kerri already chewed me out about that. But I brought some summaries about all the programs that I'm talking about. It's got a little descriptor, it's also got the name of the lead person on there, their phone number, their e-mail, and the website. So if you have more questions, please feel free to contact them. Our website is not quite up to date, I will tell you that right now, so I would rather that you contact the person. If you don't contact the person or don't want to talk to them and you'd like to talk to me, please feel free to do so, okay.

Okay. So we talked about what is the division doing and why are you doing this, Pablo. Well, as I mentioned to you, we lost what we call the CalSAMP, California Shortage Area Matching Program, and the SAMEP, Shortage Area Medical Education Program, which was a three-year pilot project that was run by Dr. Bob Montoya. He did a real good job, a very good job with the program, however there was no continuation plan developed and we lost the funding or the funding ended October of last year.

We learned some very hard lessons as a result of this. And part of those lessons are not only applicable to the CalSAMP and SAMEP programs, but they're also applicable

to a number of the programs within the Division. And some of those lessons, I have a list of them and let me read them off to you.

We learned first of all that we had a very poor tracking mechanism. We didn't know where our clients came from, our residents came from, our students came from. We knew where they went, but we lost track once we placed them. Our data collection was something less than to be desired. We had it on a Word processing instead of an Excel or Access, so that we could be a continuation with an accumulation of numbers, again, in order to validate a program. So we learned that lesson.

Through feedback from the community, we learned that we need a little more structure in the programs. Different sites were getting different portions of a curriculum, if you will. That doesn't mean it was bad, but we thought, God, what if we could standardize this and then move this forward formalized in such that anybody who goes through this program can get credit for it, i. e., the students. So that was feedback that was given to us from the community. It's not something that I came up with. I wish I could tell you I came up with all the ideas, but I didn't. It was community feedback.

We learned that we needed to add partners. We were very LA-weighted and very based because of population,

which was okay, but there are other needs in the state. So that's one of the other criticisms and constructive feedback that we received, why just LA. So we're looking to expand from what has typically been three basepoints of operation, and I'm hoping that we can do eight. That's my goal, at least for the next year or two years.

Also the other thing that was really stressed to us was the fact that we were only including the docs and the NPs and the PAs. And the comments that was made was Pablo, you guys can take care of that issue, but if you don't have clinicians, mental health clinicians, if you don't have people who are able to develop and change policy, then all you're doing is bandaiding stuff. So we needed to include people who would be able to change policy down the road, so we're adding different disciplines to the curriculum. So again that's only for hopefully the resurgence of our SAMEP program, but we're trying to do it across the board. A lot of these programs cross over and the staff in our division do not simply function in one area or the other, they cross over into different areas. And our ideal goal is to have a complete pipeline for people to go through the system.

Am I running out of time?

Okay. And here's the purpose. I'm just going to run through the purpose real quickly. We're hoping to make for a more seamless blend of programs. We want to focus on

having a wider range of ethnically and culturally diverse population of professionals. We want to assist the students in other words, we don't want students to struggle and ask where they should start. We should be the facilitator of that. We want to continue exploring in the area of improving placements in medically underserved areas. And obviously, we want to engage communities in more of this process because they are the ones who have the information for us.

And two things I'm very proud of in the division. We developed what we call a Division Policy Advisory Team. And what it is is we have the managers leading the supervisors in the division, and every Monday we meet and do, for those of you who are clinicians and that's what I was in a previous life, is we do case consultation. We bring our hardest, most difficult projects to the table and via collected wisdom we try and make decisions before we move anything forward in terms of a policy situation. It also is a good checks and balance, because as you know, when you get busy, you tend to forget certain projects. This is a reminder. There is a lot of peer pressure. There is a lot of peer support though, and we force each other's hand on this particular process. So we come in and we open and nonetheless we have some coffee and we sit down and everybody is expected to participate, and we update our

things to do list as we go and that's the way we do the process.

The last one is the Statewide Advisory Committee which is not yet in its full development. I was talking to Dr. Lawson just a moment ago. As a result of the lessons we learned from our counseling in the SAMEP program, Dr. Carlisle and Bud have approved for me to put together a statewide advisory committee. This also came from community feedback. What we're looking to do is put a committee together that will help us, help OSHPD, forge some of its policy in terms of programs and the direction we're going. And I have to tell you right now the list of people that are on this committee are impressive. We have everybody from Mr. Braumbeck from UCSF, Dr. John Blossom, has agreed to serve on the committee. We've got Dr. Laurie Williams, who is a Native American Indian representative. There's not been enough representation. We have the asian community is going to be represented. We have Dr. David Hesbastista, Dr. Hector Flores, Dr. Jaime Cruz, Dr. Cathy Flores, also here in the valley. I mean we have a number of players who have collected wisdom. I keep saying I feel like I'm in kindergarten compared to these guys in terms of the knowledge that they have relative to healthcare workforce. So I'm very proud to know that these people are really going to be -- I feel are going to be really challenging OSHPD to

meet the demands of what these people want. But I think that's the best way to make public policy and the best way to put the rest together if they're going to be affected by the committee.

Accomplishments. This is the part I hate to do, to present it to you. I hate tooting my own horn, so I will toot the staff's horn, because it's the staff that's done all the work. I've got some great staff.

This Healthcare Pathways Continuum, it seems like a very simple concept, but it was actually a very, very difficult thing to come up with. You had to really restructure mindsets in terms of how you service and learning. People were not used to crossing over. We are trying to eliminate the silo concept within the division, so that people from one cube to the next cube know exactly what is going on. We're building up a backup system, because, as you know, sometimes somebody goes on vacation or they're out sick or whatever, and nobody has information. I don't like that. I would like to know that the next cube could pick up the phone and answer the questions. So that's what we're trying to do.

When I first came on board, I understood that the Song-Brown programs had not been monitored in several years. I couldn't understand that, so what we did is we standardized the Song-Brown and developed a monitoring tool

for two reasons. Number one is to make sure we were able to evaluate the programs and see their effectiveness, and number two, to make sure that in going out people knew that we were rating them. And we did get this comment by the way. We were rating them on the same scale. In other words, so there was no differential treatment, everybody got the same thing.

And then the third component that happens, we actually got some very good feedback, was people kept saying to us, gee, we didn't know if we were doing it right, but nobody every questioned it, so I just kept doing what I was doing. So we used that as a TNTA type of facilitation and it turned out to be very positive.

I'm also asking the staff to develop a similar project for our State Loan Repayment Program, which has also again not been reviewed. I have a real tough time putting up money, public money, and not knowing what's happening to it. I don't like to have that uneasiness about it. Not that there's not a trust level, but it's better to work together than to work in the unknown.

I already talked about trying to work on the redistribution of the funding for the State Loan Repayment Program.

And then there's three Legislative-mandated studies that we've done or we've provided technical

assistance on the implementation of AB 982. The department actually got some very nice kudos. And we talked about the MSSA Reconfiguration. And the other part that I'm real proud of is we were able to attain a $50,000 grant from HRSA, even though the department is already working on a GIS component for the whole department. With the $50,000, we were actually able to focus in specifically on healthcare workforce issues, and the beauty of this, and it was done by an independent contractor, and again, the evaluation was not only done internally within the division, but they went out and they talked to CBCA. I think they also talked to -- Laurie, did they talk to your group, the California State Rural Health Association. They talked to DHS and others. We talked to people who are going to be impacted by the product that we were trying to produce. And I think that's the beauty of working collectively in collaboration. So I'm very proud of what we're doing so far in this area. And, of course, we're involved in several other committees and groups. The Racial and Ethnic Health Disparities Participant, we're working with the Rural Health Access Council, and there's quite a list of about half as more, but because of time durations, I just want to keep it to those.

Kerri, wants to get me off the stage, and I understand, but I thought it was important that you know that -- she told me she was going to hook me. But just to

let you know, I'm very proud of where I work at, I really am. I think we have a good direction. One of the things that I do like is the fact that we try not to turn our backs on people, in other words, we're user friendly. Hopefully we're reachable. We're not perfect and we're willing to listen to the public in terms of what your needs are, and hopefully we can help you with that. So with that in mind, I'll leave it to any questions that you may have.

CHAIRPERSON CARLISLE: We'll go ahead and thank Pablo for an excellent presentation about his division.

(Applause.)

CHAIRPERSON CARLISLE: As OSHPD Director, I know how lucky we are to have Pablo running the Workforce and Community Development Division. I just want to thank him for being available to serve in that capacity and thank him for his accomplishments since taking over the division.

At this point I'll ask councilmembers or representatives if they have any questions for Pablo Rosales regarding his presentation.

Okay.

And before we go on to the public comment period, let me say that if you do have questions that you want to direct to Pablo, Bud, myself, or other councilmembers, you can use these cards as a vehicle for producing the questions. I know we've had some late arrivals. And again,

if you do wish to make a public comment or ask a question, just go ahead and fill out one of the cards, which are available at the back table, and we can collect them from you. Raquel is raising her hand, and if you raise your hand with a card, she'll go ahead and pick it up from you.

Before we go on the public comments, let me just ask councilmembers if they have any updates from their respective departments that they wish to share with members of the audience at this point in time.

Ruben.

COUNCILMEMBER LOZANO: Yes. As Pablo mentioned, recently the mental health program has been added to the Loan Repayment Program, and we have gotten word out to the counties as to this participation, where it's available for them, and my guess is we will be hearing on that soon and applications will follow.

CHAIRPERSON CARLISLE: Thank you.

Mauricio.

COUNCILMEMBER LEIVA: Just an update. Regarding the budget, we have not received any information that we normally had. The Healthy Families Program continues to operate as it has in the past. In fact, the Governor has provided us enough dollars to continue to move children into the Healthy Families Program. We will be implementing Assembly Bill 1401, which will streamline the movement of

people involved in the Major Risk Medical Insurance Program. And that will help the process and in essence will make more slots available to people who have preexisting conditions.

CHAIRPERSON CARLISLE: Thank you, Mauricio.

Elizabeth, anything from DHS?

COUNCILMEMBER SAVIANO: Well, I suppose probably what's foremost on most people's minds given the events I heard last night, is the status of the Smallpox Vaccine Program and the bioterrorism money from the CDC. The latter, I can't speak to specifics. I know that Tom Ridge, from the federal Homeland Security spoke this morning to announce that monies would be available to state and local agencies to address some of the additional security needs that are occurring at state and local levels.

The Smallpox Vaccine Program in California, as of Tuesday, I understand that approximately 560 health workers in California have been vaccinated. The vaccine has been released to, I believe, 41 county and public health agencies, that's not including LA, because LA had applied for a separate vaccine program, and that there are at the state level several hundred State DHS employees who have volunteered to be vaccinated. Our Director, Leanna Bumtaugh, was vaccinated immediately, and it's been a couple weeks ago now.

And there is some question about whether or not

the second phase of the vaccines are going to be able to be stepped up, particularly since we are now at war, and I don't have any information about that. Phase Two would be vaccination of first line responders, that would be higher emergency and police force workers. So that we don't have any information on at this point.

CHAIRPERSON CARLISLE: Thank you, Elizabeth.

And Maureen.

COUNCILMEMBER MCNEIL: I do have a couple of items. We're going to be proposing to expand our Emergency Medical Technician One scope of practice to include seven new medications and one new procedure. One of the medications I think will be of particular interest are Mark One kits, and these are autoinjectors that are used to treat emergency responders and patients who have been exposed to some type of a bioterrorism attack. This proposal probably will be issued in regulations sometime this summer.

Another project that we've been involved in is obtaining a federal grant to purchase automatic external defibrillators to distribute in rural areas. Rural areas submit applications for this funding and our awards for the funding has just gone out in a press release. We will be provided 52 automatic external defibrillators to rural areas via this grant process.

CHAIRPERSON CARLISLE: Thank you very much,

Maureen.

Well, at this point, it's a pleasure to move forward to the public commentary period. And we have several comments already that we will hear from. And again, go ahead and submit cards if you wish to participate.

The first is from Ned Miller from Bloss Memorial Medical Center.

Ned, go ahead and take it away.

MR. MILLER: Kerri said there's a microphone and we should come up to that. So just a warning for everybody else, I guess. You don't have to do that, but I think that would be better.

I'm Ned Miller, the CEO of Bloss Memorial Healthcare District in Atwater, California. I've come here today just to talk about something that is in the process of developing regarding population shifts based on the 2000 census, which we have been notified by the feds could affect 20 or more rural health clinics in California, ours being three of those. In going back to Baltimore and talking with the feds about this, they indicated that instead of a hundred across the United States, perhaps 200, which means perhaps in California more rural health clinics could face possible deactivation as rural health clinics.

Based on the census and using federal standards, we'll be no longer considered rural. Looking at our

populations, the unemployment rates, the minority situation, the low payment to doctors for MediCal, which most of them don't want, we certainly need to continue to exist. We'd like you to help us intercede with the feds to find out what their plan is. They said there would be some exemptions. We have not heard yet what the exemptions will be. I don't know if they plan to allow us to become FQIC lookalikes or if they will go ahead with this exactly, but many of the rural health clinics in the valley, particularly in the central valley, feel very threatened by the potential of losing their designation.

I know in talking with members from different clinics, they feel very similar in their situation as ours. I know in the Merced County area, we've lost 17 doctors from what we had five years ago. Those doctors, most of them, will not take MediCal. If our rural health clinics are lost, these people, first of all, do not have the transportation to travel far to get care, and secondly, when they do get places, they will crowd up the emergency rooms if the rural health clinics are lost.

So we do hope you will help us look into this with the feds and see if they can change their definitions or see if they will give the exemption to allow us to remain. Thank you.

COUNCILMEMBER LEE Thank you, Ned.

I'll respond, it came under the Council's radar and since I have an inside track in OSHPD, I think we can work something out here. We're arranging for a briefing of ourselves by members of this audience, actually, in more detail of what this situation is. The way that we understand it is the desires of the rural communities in California would be rather than have to submit exemption requests on a case-by-case basis, why doesn't the federal government acknowledge the use of our geographic configurations, and rather than adapt it to some configuration that was developed in the state of Washington that may well apply in other states. That's our understanding. We're in the process of looking to see what it is we can do on that, and we'd have to work with our own Health and Human Services Agency, but that's something that's well in progress.

MR. MILLER: Thank you.

CHAIRPERSON CARLISLE: Next we'll go ahead and hear from Mr. Fred Johnson, who is the President of the California State Rural Health Association.

Fred.

MR. JOHNSON: Good morning, Mr. Chairman, Members of the Council. I'm very pleased to be here today.

I'd like to start off by thanking you for taking time from your busy schedules to make the trip down here.

It's very important to us and to be here in conjunction with the Rural Symposium. And I also wanted to thank you for having a representative at the California State Rural Health Association's Educational Workshop yesterday afternoon.

My name's Fred Johnson. I'm currently president of the California State Rural Health Association, and a few introductory remarks. I wanted to also thank you very much for the handouts at the back of the room. The periodic report from your Executive Director is most helpful and all of the other information, including the grants timeline and the jobs available information.

On a personal note, I would really like to commend Dr. Carlisle and Bud Lee and Pablo Rosales for making a lot of the changes that have been a long time coming at OSHPD. And I think that it serves the people of California much better. It's taken a lot of courage and it hasn't gone unnoticed it's fair to say.

Today I have provided you with some written testimony and requests, and the California State Rural Health Association views the California Rural Health Policy Council as our partners in the executive branch of the California State Government. We hope that you will view the California State Rural Health Association as your partners on the private side.

And so it's kind of with that that we're going to

give you some requests today. These requests seek support from federal and state activities which preserve and enhance health in rural California, and that's the core mission of our association. This happens to be the first time, I believe, that the State Rural Health Association has ever testified before your council, so please bear with me.

Also prior to the next public meeting, we would very much appreciate to hear from you about the status of each of the requests that we are making of your today.

CSRHA and rural communities appreciate and value the important role your council and each councilmember here today plays in our combined efforts to improve the health of rural California.

Now, I will move into topics and requests. And we've provided you with the issue, the request and a little background. I wanted to say that we would be very pleased to provide any additional information that the Council or any of the members would like to receive or participate in any way to help you as you deliberate with these requests.

The first request has to do with federal funding concerns. I might as well hit the big one first. And our request is it is requested that the California Rural Health Policy Council send a letter to the appropriate federal officials supporting federal funding levels as recommended by the National Rural Health Association for federal fiscal

year 2004.

Topic Two under federal issues is the Medicaid overhaul. It is requested that the California Rural Health Policy Council identify the impact of the proposed Medicaid or MediCal in California changes on rural California, and to provide that information to Mr. Tom Stoley, Administrator of Centers for MediCare and Medicaid Services; Governor Davis and other officials as appropriate.

In the area of federal definitions issue, we are requesting that the Rural Health Policy Council send a letter to the federal Office of Rural Health Policy requesting that California be exempted from the rural/urban commuting areas methodology and that the federal government accept and use the California Health Manpower Policy Commission's and also this council's definition of rural as administered by the California Office of Statewide Health Planning and Development. The federal government just doesn't understand what a rural area in California is and OSHPD does.

Under state issues, I have a few. One is maybe a little easier one. In the area of viewing healthcare in a different light really is a source of economic stimulus, we're requesting that your council annually, once a year, conduct a joint public meeting with the California Rural Development Council, which is located in the Trade and

Technology Commerce Agency, and also include the Governor's Office of Planning and Research Rural Taskforce in that public meeting. And really the goal would be to open up communications to get economic development more keeping healthcare on their spotlight and getting healthcare to think more that we really do a lot of economic development.

The next area is in the area of workforce and education. Just a comment and then the request. The comment is that rural California suffers from an across-the-board workforce shortage of physicians, mid-level practitioners, allied professionals, dentists and dental professionals, pharmacists, mental health professionals, and other specialties. In the area of health education centers, we request that this council support the development of new, they call them AHECs, the Area Health Education Centers in rural California, in rural areas of California.

The next topic is the J-1 Visa Waiver Program. It's a federal program that was started a few years ago, of which California has been participating. It is requested that this council support California's continued participation in the J-1 Visa Waiver Program should events such as realignment change the current landscape.

The next issue under state is bioterrorism. And it is requested that the California Rural Health Policy Council, and particularly EMSA, support the inclusion of

rural officials in all urban evacuation planning activities and that those urban agencies provide assistance to rural areas whenever possible. Especially with bioterrorism, there's a lot of planning going on and they're moving the population out of the urban areas into the rural areas, but they aren't including the rural folks at the table and those discussions.

The last issue is the state budget and health program cuts. And I know you're all in a difficult situation and we're all challenged, but we couldn't end today without requesting that the Council advocate for rural health programs to be protected from being unfairly disadvantaged in California's 2003/2004 state budget, as rural communities lack economies of scale and only have minimal resources and services to begin with.

Thank you very much. I'd be happy to field any questions you might have.

CHAIRPERSON CARLISLE: Fred, thank you very much for those comments.

Councilmembers, do you have any additional comments or responses for Mr. Johnson?

Fred, thank you.

MR. JOHNSON: Thank you very much.

CHAIRPERSON CARLISLE: Next we have Deborah Page from Delta Dental.

MS. PAGE: Hi, my name is Deborah Page and I'm the Provider Relations/Provider Networks Coordinator for Delta Dental State Government Programs.

I'm looking to the question on the status of the Prop 10 Commission's project that we've heard about, and because Delta not only is very active in Healthy Families, but we've also been active in local, counties providing care to low incomes in those counties. We just like to see what else is out there and what the status is?

COUNCILMEMBER LEE: I think you may have caught me a little off guard. I'm not quite that familiar with the Prop 10 Commission Project.

COUNCILMEMBER LEIVA: Thank you for that question, Ms. Page. At the March 5th meeting of the Medical Insurance Board, they authorized us to enter into a contract agreement with the California Children and Families Commission. They are proposing a project which would target the children under five, five and under, for special access to dental care. We plan to have a proposal solicitation out in April. And the project will be administered similar to the Rural Health Administration Project. As you know, the Rural Health Administration Project has been designated to be cut in the next budget year. Although the Oral Health Administration Project will not be the same as the Rural Administration Project, they will be similar and we will be

using basically the same infrastructure where plans will collect proposals from clinics, especially dental clinics, that are interested in participating in the project.

CHAIRPERSON CARLISLE: Thank you, Mauricio.

Okay. The next comment is from David Green of the Kern Valley Healthcare District.

David.

Again, I would encourage anyone to go ahead and submit comments for the public discussion. Again, thank you.

David.

MR. GREEN: Thank you. I'm David Green, the CEO of Kern Valley Healthcare District.

I'd like to thank Bud for exactly a year ago, I guess, that we took on a project and Bud helped some of us come together to work with the Department of Managed Care in getting some parity, I like to call it parity, in how we deal with things. But given the unique situation with the rural healthcare and the cost of maintaining that care there and trying to keep it alive.

First I want to compliment you and appreciate what you've done to help us in dealing with the Department of Managed Care. The disappointment side though is we're still working on that and I know you gave a report on it. My question is in that comment regarding the regs that are

being drafted, a population of 500,000, the population of 500,000 or under, there are many of us and three of us that were on that committee that are in counties of populations greater than 500,000. For instance, Kern County has 600,000, but Bakersfield doesn't think there's anything east of the mountain ranges which we're on the other side of. And I think there's at least three of us on the other side of those mountain ranges.

It's these kind of situations that we want to make sure are addressed in that. Is there any way for us to make sure that we don't get excluded in those considerations, because there are some vast areas in those counties. Thank you.

COUNCILMEMBER LEE: Thank you for reminding me of how long we've been working.

(Laughter.)

COUNCILMEMBER LEE: I think what I'd like to propose, David, is in conjunction with yourself and Ray and Jim and others who have been with us all this period, in conjunction with Sharon and anybody else in a similar situation, I think it would be -- the best thing to do would be for us to arrange a direct conversation between you who are affected by this 500,000 population limit in a direct discussion with the DMHC people who are going to be responsible for that.

In just a very mild defense, they have lost some leadership. Some of their leadership got promoted out of the department, and so they are trying to recover from that a little bit, which contributed to some of the delay over the late last part of last year and early into this year. But I think that perhaps, and so you wouldn't have to travel all that way, I'm sure we can arrange some video conferencing. I think through us we would be happy to put that meeting together so that you can talk to them directly and that we can help advocate for you within that executive branch. And we would put that together as quickly as we can, if that will work for you.

MR. GREEN: It sounds good.

CHAIRPERSON CARLISLE: Okay. Our next comment is from Kathy Yarbrough of the Rural Health Design Consortium.

Kathy.

MR. YARBROUGH: I guess I'm the last speaker. I want to thank you for this opportunity and to thank you for the support that you've shown the Rural Health Design Consortium this last couple years.

For those of you who don't know who we are, the Rural Health Design Consortium was started several years ago at the Summer Summit and it was a discussion held with an architectural gentleman by the name of David Hitchcock and some rural health administrators, and they were all

bemoaning over a couple cocktails the anxieties that were being addressed to them by SB 1953, which I think some of you might be familiar with.

What that conversation led to was several other meetings, and we finally did bring together a group of 23 hospitals that had an interest in really looking at how we could work as a group. Of that 23, 13 hospitals came together and put together a group, and we had a wonderful budget of $60,000. We made that $60,000 last for two and a half years. It was a very interesting budget. Because this group of 13 hospitals also did in kind and -- David Hitchcock also provided lots of in kind.

And I guess I could go on and on about the Rural Health Design Consortium, but I just want to say that we started with an idea that we were going to work together to design a core facility that we were going to use in all 13 communities. So we had this wonderful idea, we thought it was a great idea, we thought everybody would just rush to fund us. Well, not everybody rushed to fund us, and after meeting on a monthly basis for about a year, what we came up with was that really wasn't the best idea. But really what the issue was was what needed to be in these rural communities, what type of services made sense in rural communities.

And one of the things we did was an OSHPD, we're

using an OSHPD study. And we looked at what type of patients were being cared for in our rural communities, how many of those patients were from the rural communities themselves, what was really happening as far as care delivery, and what we discovered very quickly is that rural hospitals in the state of California care for almost 100 percent of the DRG statuses, and that was amazing to us. Almost every hospital has done some sort of aortic aneurism repair, and that's pretty scary when you start looking at what is happening in some of these communities with the facilities that do exist.

And so what we determined was we needed to change our focus. We needed to look at what was appropriate, what was reasonable, and what was sustainable. And when we did that, we started changing our grant applications, we started to get some interest. And our focus is still trying to come up with a facility that would make sense in rural communities.

We were very fortunate in getting -- as you all know, every one of you sitting here has gone after grants. We finally found a champion within the California Endowment and we were able to have success. We did get a grant recently of $194,000. And that then led to a donation grant basically from the California Health Collaborative to get to $200,000, which then tripped in a donation of $50,000 from

Vega Healthcare Group. And so we have a quarter million dollars to do our group, to do our study.

And one of the things that we did is our group, everybody wanted to be the beta site, and so what we have been hearing from the very beginning is that you're never going to get hospital administrators to agree on anything. They all have different issues, and they all need something, and it's very difficult for them to think as a group. Well, one of the things that we've been able to accomplish over the last two years is to get hospital administrators that have a little bit of a groupthink and they selected Tehachapi to be the beta site for our group.

So what we will be doing and what we've already started is working with Ray Heno and his group and community advisory committee is that we are developing a replicable community assessment process that other rural communities can go forward and use in their communities to make sound decisions on what should be there, and it has to be community driven.

We've heard today from many groups talking about the success of programs and the success of programs are having the right people at the table and then engaging your community in this process. So what we know is that we have to be -- we have to really work at getting people involved. What we know that we will be asking OSHPD and the Department

of Health Services is addressing some of the legislative issues, as far as what is required of these facilities, looking at licensing categories, and really looking and thinking out of the box and coming up with something that makes sense, is easy to build, is less expensive to build, and can be built on a quicker basis.

So we're still looking at the building component, but what we're really looking and focusing in on is getting the community to understand they have to help and work very closely with their health community, whether it's a hospital or clinic or whoever in that particular community and doing it from a position of making the community healthy.

So it's been an interesting process, I really enjoyed the journey, and I know that we will be talking to you on a regular basis as we go forward with this. So thank you very much for this opportunity.

CHAIRPERSON CARLISLE: Kathy, thank you.

We also have a comment from Kevin Erich of Howard Memorial Hospital.

Kevin.

MR. ERICH: Again, my name is Kevin Erich from Howard Memorial Hospital in Willits, California. And just a couple of comments. First of all, actually, a couple of years ago I got up here and I said some things that I was frustrated with, and I do want to thank Bud Carlisle and his

team, because they actually responded very quickly. And I had some issues that seemed to be dragging on, and within two weeks actually I got resolution to those issues.

So I'm not going to give you a whole list of issues here, but I do want to -- and several things that have happened over the last little while that are still some issues of frustration. One of the primary ones for me is with small projects and dealing with small projects and getting the approval process on small projects, and how it seems oftentimes those projects take just about as long as some of the bigger projects to get the approvals for. And I guess I would just strongly encourage the department to take a look at ways we can -- you know, if projects, and I'm just throwing out a number here, maybe less than $20,000. You know, maybe it's more appropriate to say $10,000, I'm not sure what's the best. But my suggestion would be for a less than $20,000 project to try to find a way that we can actually within a month or at least 60 days get the approvals that we need to be able to continue on and get these projects accomplished and taken care of. That would really be a plus, I think.

And Pablo's discussion earlier about how paperwork is piling up, and I understand that some of the cutbacks at the department and the inability to replace some of the individuals in the department, you know, is just going to

make it worse and worse. So I think if you get paper on your desk and off your desk faster the better.

(Laughter.)

MR. ERICH: So I would strongly suggest that you take a look at that.

Also, I've been dealing with some seismic issues. But I want to say that on the paperwork side it's been a frustration at times to send paperwork back and forth, but I actually went into the Sacramento office and met with the individuals that were responsible for our project. And actually that helped me a lot in understanding the process, understanding what needed to be done, where we were and actually Patrick Rogers and Chris Hokus, both of those individuals I worked with, and actually I'm very thankful for the help that they gave me. Even though it took me to actually go to the office, it wasn't their fault, it's just that the process, sometimes the bureaucratic process can be really sort of a mess, as all of us know. And I appreciate the help that they gave me in that process.

Another concern that I've had is it depends upon the office that you deal with and the individuals even within offices. But this is actually addressed at DHS. I would sure like to see us work toward more of a consultive supportive role, and at times I see that, but at other times it seems like it's very disciplinary in nature route to get

you, we're going to get you one way or the other, or you either do what we say or else you're in trouble. And that is what the job is, I guess, of DHS is to survey us and make sure that we're complying. But I know at times it's been difficult when you get on the phone to try to ask for information, the response basically has been we're not here as consultants, we're here to basically survey you and to make sure you're in compliance.

And to me that's rubbed me a little bit the wrong way because I think we're in this process together, we need to be working together for a common goal and a common purpose, and I'd like to see the DHS department strongly encourage its employees to try to be consultive in nature and very supportive of the hospitals and try to help us find solutions to some of these problems.

I come from a very small hospital, I don't have a lot of resources, and you know it's very expensive also to bring in outside consultants to come in and try to do some of these things. And if the office could help us with some of these processes or give us suggestions, I would sure immensely appreciate that. And, again, this is not all negative, because I have worked with some individuals from DHS who have been very supportive and they have done that. But there are others that have not. And I'm not going to be listing names here, I don't think that's appropriate, but I

would just like to strongly encourage you to pass that on to your employees that we would sure like to have more of a supportive role and one of working to a common goal instead of maybe against each other.

Thank you very much.

CHAIRPERSON CARLISLE: Kevin, thank you very much. With regard to your project review comment, actually our Facilities Division does sort of stratify between very big projects and less than very big projects already. And I hear the point that maybe we should also think about some other stratifications to move things along. And so we'll certainly take that comment back to the office and discuss it and see if we can reach some sort of accommodation. Thank you.

MR. ERICH: Thank you.

CHAIRPERSON CARLISLE: Any other responses to Kevin?

Well, we have no other public comments submitted. At this point we're approaching the close of the meeting. I just want to on behalf of OSHPD, just make a little advertisement. We have with us Dale Thorny. Dale is the Deputy Director in charge of our Cal-Mortgage Program that provides insurance to healthcare facilities to ensure loans that they use for capital expansion and other projects, and I just want to make sure that everyone knows who Dale is and

he's available to you if you wish to discuss facility financing.

Dale, thank you very much.

Well, I think that we have actually reached the end of the Rural Health Policy Council. I don't have much in the way of closing remarks. I want to thank all of you for being here. This is a very large attendance and it's wonderful to be up in this part of California again.

Bud and I, and I think the other members of the Council, will probably be available for a few minutes afterwards if you want to come up and speak to us individually.

But again, thank you very much everyone for being here. I don't know the date for the next meeting at this point, but we are looking forward to seeing you again in the near future and certainly don't hesitate to contact us or the office or the Council in the interim period.

Thank you.

(Thereupon the meeting of the Rural Health Policy Council on March 20, 2003, was concluded at 10:10 a.m.)

CERTIFICATE OF SHORTHAND REPORTER

I, MICHAEL J. MAC IVER, a Shorthand Reporter, do hereby certify that I am a disinterested person herein; that I reported the foregoing Rural Health Policy Council proceedings in shorthand writing; that I thereafter caused my shorthand writing to be transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said Rural Health Policy Council proceedings, or in any way interested in the outcome of said Rural Health Policy Council proceedings.

IN WITNESS WHEREOF, I have hereunto set my hand this 15th day of April 2003.

Michael J. Mac Iver

Shorthand Reporter